HOLZER MEDICAL CENTER
100 Jackson Pike
Gallipolis, OH 45631
(740) 446-5363 Phone
(740) 446-5693 Fax

HOLZER MEDICAL CENTER-JACKSON
500 Burlington Road
Jackson, OH 45640
(740) 395-8307 Phone
(740) 395-8519 Fax

I, _____ hereby authorize HMC
(Patient) (Organization)
to release copies of my personal health information concerning my hospitalization or treatment, including but not limited to, information concerning drug related conditions, alcoholism, psychological and psychiatric conditions, and including the release of information containing HIV testing, AIDS diagnosis, AIDS related conditions, or permit review of the same, provided however, that such release is limited specifically to material of the following nature and extent:

Date of Birth: _____ Date of Service _____

Information to be Released (check all that apply)

_____Face Sheet	_____History and Physical	_____Discharge Summary
_____Lab/Path Results	_____Radiology Reports	_____Radiology Films
_____Consultations	_____Operative Reports	_____Physician Orders
_____Progress Notes	_____Nursing Notes	_____Emergency Department
_____Entire Record	_____Other	

Exclusions (please be specific) none

The above information is to be released to: Attorney Kevin Kurgis
(Name of person or organization)
100 S. 4th Street, Suite 300
(Address)
Columbus, Ohio 43215 614-464-1610
(City, State, Zip) (Phone/Fax)

The purpose of the authorized use or disclosure of the information described above is as follows:

_____Continuity of Care	_____Personal Review	_____Insurance
_X_Attorney	_____Other (please be specific) _____	

The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization, except in certain stated circumstances. As described in the Notice of Privacy Practices Holzer Medical Center/Holzer Medical Center-Jackson, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by HMC/HMC-J in reliance on this authorization, by sending a written revocation to the MIRS Department at HMC/HMC-J. This authorization will expire in 60 days from the date of signature. A photocopy of this authorization may be used in lieu of the original. I understand that if the person or entity that received the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by federal privacy regulations.

_____ _____
Patient Signature Date

_____
Other Person Legally Authorized to Give Consent

_____ _____
Witness Relationship to Patient/Reason

* ROI *

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